RELATIONSHIPS AMONG THERAPISTS' ABSENTEEISM, CASELOAD AND PERCEPTIONS OF CHANGE, SATISFACTION AND BURNOUT

by

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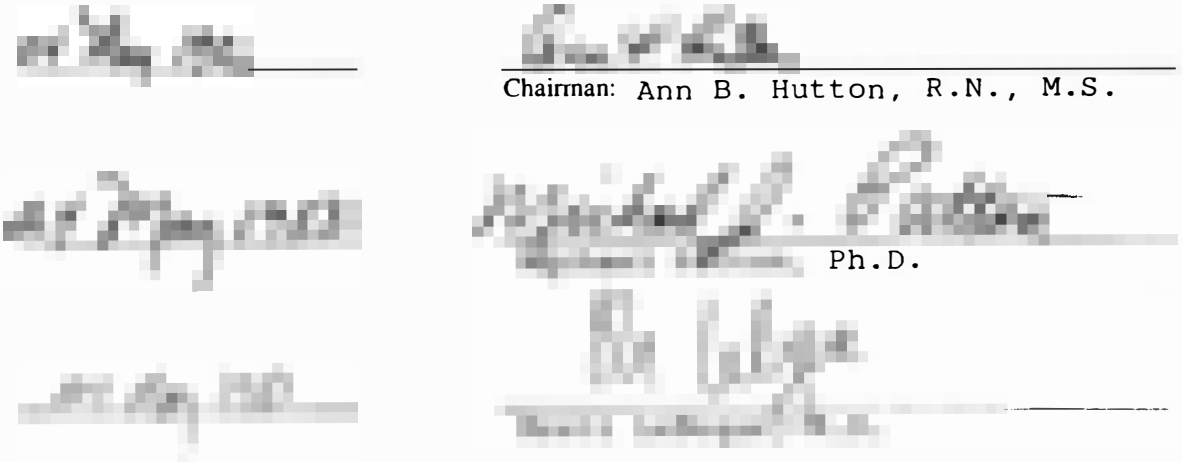

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ABSTRACT

The purpose of this research was to examine the relationship of stress as measured by the variables of perceived change, type of caseload and the existence of symptoms of burnout, on job satisfaction, absenteeism and burnout. The investigator wished to determine if reported institutional variables were significant in outpatient mental health center settings.

The sample consisted of 74 community mental health center staff employed in six units.

Data analyses included descriptive statistics on all the questionnaire items with selected correlations being performed.

The results of the study showed the predicted inverse relationship between burnout measures and job satisfaction. A moderate correlation between self-reported job satisfaction and episodes of unscheduled absenteeism was obtained. In addition, a similar relationship was found between job satisfaction and self-reports of feeling burned out.

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CHAPTER I

INTRODUCTION

Stress is a phenomenon which has been the focus of considerable research and attention in both the scientific and lay literature. Its study began centuries ago, but the individual most recently noted for beginning the research in this area is Selye (1956), whose research has stimulated others to recognize the importance of the effects of stress in human functioning.

Stress has been studied as it relates to four areas: a) the biological sciences; b) the occurrence of specific diseases; c) its effect upon organizational efficiency; and d) its impact in various occupational or professional categories. This latter approach is most commonly known as the study of job-related stress, and the associated phenomenon of burnout.

Burnout is a syndrome consisting of a set of behavioral, affective and physiological responses which occur as a result of an individual's failure to cope with stress. The syndrome is characterized

by physical and/or emotional exhaustion and loss of positive feelings toward clients or toward oneself. It is frequently associated with those in the helping professions, and is considered to be the result of a failure to adequately cope with stresses related to the job. Within the mental health system, staff from various disciplines are often responsible for large, difficult caseloads, particularly those associated with chronic mental illness. Wolfe (1981) reports the incidence of burnout increases in direct proportion to the number of chronic schizophrenic patients an individual has on his/her caseload. In addition, numbers of other factors appear to contribute to the incidence of burnout among mental health professionals. These include changes in administrative policies, large caseloads, uncooperative clientele, personnel relocations, and many other circumstances outside the control of the individual.

Positive correlations have been demonstrated between high job stress and a host of undesirable psychobiological sequelae resulting in compromised worker productivity (Appelbaum, 1980; Margolis, Kroes & Quinn, 1974; Michaels & Spector, 1982; Wolfe, 1981). These job stresors and their consequences need to be identified so that intervention strategies can be

designed to reduce employee uncertainty and increase a sense of perceived control in order to counter the undesirable effects of stress.

Institutional settings have been the primary source of research in the areas of stress and burnout (Pines & Maslach, 1978). From the results of these studies, general inferences can be drawn to outpatient units, but not without some difficulty because of the differences in the nature of a community mental health center's organization as opposed to a hospital. The investigator was interested in studying the characteristics of stress in an outpatient setting to see if the same variables reported to be significant in institutional settings might also be significant in an outpatient mental health center setting.

Problem Statement

The objective of this study was to explore the relationship between stress as measured by the variables of perceived change and type of caseload, and the existence of symptoms of burnout, degree of job satisfaction, and amount of absenteeism. Absenteeism has been reported to be an indicator of burnout (Ansell, 1981; Maslach, 1978).

In a community mental health setting, different types of caseloads have their own inherent problems

and stresses. It has been demonstrated in the literature that certain types of job stressors are more likely to lead to burnout and ineffective coping than other types of job stressors. This study compared the coping responses of mental health center staff working with caseloads primarily composed of chronic mental patients, with those of staff whose assignments were comprised of more typical outpatient clients.

Rationale and Significance of Research

Few controlled studies of the relationship between stress and burnout have been reported in the literature. Researchers in the areas of law enforcement, education, social work, nursing, physical therapy and more recently in mental health organizations have begun to apply scientific methods of investigation to the burnout problem. Although research within mental health centers is limited, the studies that have been done appear to agree that a high rate of burnout exists among those in the helping professions (Ansell, 1981; Freudenberger, 1977; Lamb, 1979; Mendal, 1979; Michaels & Spector, 1982; Pines & Kafey, 1978; Pines & Maslach, 1978; Scholom & Periman, 1979; Wolfe, 1981).

This research suggests that the type of clientele, the therapist's individual characteristics and the

organizational requirements appear to be the major factors contributing to the syndrome of burnout. While no studies have been done which demonstrate the percentage of burnout among helping professionals, a number of investigators have suggested that high rates of absenteeism may be one significant index of burnout occurrence (Ansell, 1981; Maslach, 1978).

Mental health center therapists are often in difficult, demanding positions. They are expected to be able to treat and manage clients with a wide range of problems. At the same time they are expected to maintain unfailing, positive feelings toward both their treatment obligations and administrative management requirements. Frequently this must be accomplished without adequate support. Therapists may be unprepared to work properly with the type of client who requires a multidimensional approach to intervention. They frequently find that their idealistic, humanistic values and limited therapeutic skills are insufficient to meet the multiple needs presented by the chronic client. Conflict and stress often arise as the therapist confronts: a) idealistic views of what should be done; b) realistic limits on what can be done with certain client types; and c) his/her own skill and energy limits. This naturally leads

to feelings of frustration, helplessness and stress which, if chronically present, can result in the burn-out response.

Traditionally organized systems all promote some type of emotional stress. Stress may be experienced from a variety of sources within the system: a) the time demands; b) the intensity of encounters experienced on the job; c) the type of environment surrounding the job; and d) the reward expected from the job.

The sources noted above may threaten or exceed the therapist's coping mechanisms and create stress. Burnout may then occur as a response to stress and may lead to a decrease in job satisfaction, low morale, absenteeism and difficulty in coping with change.

It is essential that therapists understand their own capabilities and limitations, the realities of treatment and management of difficult clients, the nature of the organizational system and the signs and symptoms of burnout and their vulnerability to it. In order to prevent burnout, it is necessary to identify the sources of stress and the meanings these stresors have for the staff member, so that more effective coping can be instigated or the source of stress altered. Administrators share responsibility for understanding their role in both generating and

ameliorating stress, for example, helping to support staff who work with chronic clients by increasing their perceived efficacy as therapists and working to decrease their feelings of guilt, frustration, and helplessness. It was anticipated that the results of this study along with other similar investigations, would assist administrators, therapists and managers to identify potential sources of stress, and undertake corrective action.

Relevance to Nursing

Although this study investigated and gathered data from subjects in an integrated mental health team, nurses made up approximately one-sixth of the subjects. As a result of medication treatment requirements, nurses are frequently assigned to the units where the chronically mentally ill client is the major focus of treatment. Mental health nurses, like many other team members working with clients in this area, are lacking in training for identifying and managing stress and burnout. Nurses often coordinate the integrated team and therefore, may be in positions to influence and direct investigations about stress which could contribute to our understanding of burnout and to the development of theories and intervention strategies.

Theoretical Framework

The theoretical framework upon which this study is based is two-fold. First, various stress and burnout models and theories are reviewed. Second, an operational model of stress and burnout is presented which outlines the variables associated with this study.

Stress

The term stress appears in the literature in many forms. For the purpose of this study, stress has been examined from the perspective of three major areas: a) as a response; b) an interaction between a stimulus and the environment; and c) as a stimulus (Spring, 1981).

Viewing stress as a response provides a framework for understanding the various phenomena associated with stress. As a response one sees a change in the homeostasis of biological, physiological, psychological or behavioral functioning. The individual experiences stress based upon either changes within the autonomic nervous system, alterations in mood states, or problems in individual performance (Spring, 1981). These reactions are the nonspecific responses to stressors or stimuli identified by Hans Selye (1956). He is best known for his research in the area of the physiological response to stress. He defines stress as

a nonspecific response of the body to the demands made upon it. His is a stimulus-response model where stress is seen as both necessary, valuable, and useful, but if not adequately coped with sustained activation of the stress response can lead to diseases of mal-adaption. These diseases effect the cardiovascular, renal and gastro-intestional systems and can be seen in increased rates of respiration, metabolism, blood pressure, pulse and muscle response.

Stress can also be viewed as an interaction between individual traits and how the individual relates to his/her surroundings. A situation is perceived to be stressful if the individual's coping mechanisms fail to deal with the situation. Stress is perceived as the consequence of the interaction between stimulus and the idiosyncratic responses of the individual (Matteson & Ivancevich, 1980). To understand whether or not an individual will suffer from a stress response or not depends upon three things: a) the individual's cognitive style; b) the individual's coping resources; and c) the individual's environmental supports. Lazarus (1975) describes stress as occurring when any interaction between an individual and an event taxes or exceeds the adaptive resources of an individual or system. The event may be internal, external or

both. Individual cognitive appraisal of the situation is necessary in order for the perception of a potential stressor to be identified as a challenge, a threat, or one of harm and loss (Bailey, 1981). The event and the perception of the event are of equal value in determining whether or not an adaptive or maladaptive coping response occurs and a stress response ensues. Stated another way, what one person perceives as stressful another may perceive as a challenge.

Cognitive appraisal is of primary importance in determining whether or not an event is perceived as stressful. Such appraisal will influence the coping strategies the individual will use to cope with the stresor. In this study it was assumed that high perceived job stress, as a result of organizational change over which staff members had little control, would lead to feelings of helplessness, increased anxiety, and uncertainty regarding the impact the change would have on their functioning. The results of the appraisal process and the associated feelings, feedback to further modify the perception of stress, to either decrease or magnify the intensity of the stress response, and eventually determine the effectiveness of coping. Signs of burnout would indicate a breakdown in coping effectiveness.

Third, stress can be viewed as a stimulus acting upon the individual to produce the psychophysiological response. In this view the stressors occur independent of the individual's traits or actions. There is a suggestion according to this view that certain types of stressors lead to specific types of disorders. Holmes and Rahe (1967) developed a scale of life changes that could be either positive or negative but which appeared to be stressful nonetheless. The amount of readjustment necessitated by the individual is the measure of stress. It is rated as high if one experiences a lot of readjustment or low if only minimal adjustment is necessary. From their research they acquired evidence to suggest that somatic and psychological illness are associated with a high life change score, although the type of illness is non-specific. From the Holmes and Rahe (1967) studies it can be inferred that individuals respond as if they have been stressed (with disease) even if they are cognitively unaware that stressors have occurred. This research suggests that we may often be initially unaware of stress because we fail to identify "positive events" (e.g., marriage) as salient stressors, as well as being unaware or denying the effects of negative events.

The model of stress represented by Lazarus' research seems to best represent the interaction between perceived stress and symptoms of burnout. Bailey (1981) summarizes the model:

1. The identification of stress is based upon one's perception;
2. The traits of an individual are important in determining how he/she sees things;
3. Stress responses (coping) may be adaptive or maladaptive;
4. Job environment can play a part in whether or not stress is related to the job; and
5. One may learn new and more appropriate ways to manage stress in addition to learning ways to reduce the impact of stress (p. 7).

Burnout and Absenteeism

If an individual experiences ongoing stress and fails to cope adequately with the stress, a maladaptive response may occur. This response may be physiological, psychological or both, and may eventually lead to burnout. Burnout as a consequence of stress has received considerable attention recently, particularly as it is experienced among the helping professions (Freudenberger, 1980; Kahn, 1978; Pines & Kanner, 1982; Spaniol & Capunto, 1979; Wolfe, 1981). Maslach

(1978) defines burnout as "a loss of concern for people with whom one is working. Characterized by an emotional exhaustion in which staff no longer have any positive feeling, sympathy or respect for clients" (p. 113).

Wolfe (1981) and Ansell (1981) add to Maslach's definition the feelings of frustration and failure. For the purpose of this study burnout is defined as a combination of behavioral (apathy, bordeom, absenteeism) and physiological (exhaustion, fatigue) aspects coupled with various emotional states (lack of concern, frustration). Burnout like stress is not an all or nothing phenomenon. It occurs in varying degrees along a continuum from mild to severe.

Pines and Maslach (1978) identified two categories of variables which influence burnout: a) characteristics of the institution; and b) personal characteristics of the individual. The data were collected on over two hundred nurses, social workers, psychologists, volunteers, attendants and psychiatrists in mental health institutions. The results identified the following institutional variables as being significantly correlated with burnout:

1. Work was perceived as less stressful if the workload was shared;

2. Higher-ranking staff members who spent more time in administrative work, liked their jobs and patients less;
3. Staff who spent more time with other staff rather than with patients felt like failures in relation to their jobs and to their patients;
4. Lower-ranking staff spent more time in direct contact with patients than high-ranking staff;
5. There was a positive correlation between increased staff stress, negative feelings, and long work hours;
6. Time-outs increased favorable attitudes toward schizophrenic patients;
7. Negative and dehumanizing attitudes toward patients were correlated with an increase in the number of staff meetings;
8. Staff members perceptions of work, patients, the institution and their peers were related to the quality of the interaction between staff and patient;
9. Staff attitudes toward work, patients and the institution effected the work relationships;
10. There was a decrease in job satisfaction for those working with the target population

diagnosed as schizophrenic; and

11. The more clients per individual staff person, the more job dissatisfaction occurred.

Personal characteristics of the staff were felt to play an important role in their perceptions of their patients, their job and of mental health in general. Pines and Maslach (1978) found the following personal variables to be significantly correlated with burnout or failure to experience burnout:

1. Staff with more formal education became disenchanted with the job conditions and felt pessimistic about curing schizophrenia;
2. Staff who had worked longer in the field seemed less enthusiastic with their work;
3. Positive attitudes and self-confidence were higher when staff felt they had input into agency policymaking;
4. More time in direct contact with patients and less time in administrative work and with staff lead to staff's description of the relationship with a patient as being close;
5. Part time work, smaller caseloads of schizophrenics and less time in administrative work promoted positive attitudes toward mental

health; and

6. Staff who had worked for a shorter time in mental health versus a longer time, appeared to be less custodial and more humanistic to patients in their approach (pp. 235-236).

Pine and Maslach's study concluded that mental health therapists working directly with patients over long periods of time experienced more personal stress in an institutional environment. They suggested that if reduction of stress or the assurrance of adequate coping skills does not take place, then the chance for burnout increases. The variables mentioned above should be further studied and explored, specifically as they pertain to an outpatient setting eventually to determine the nature of their relationship with burnout and the potential for systematically intervening to prevent burnout.

Ansell (1981) described a variety of symptoms which manifest themselves when one begins to experience burnout. The manifestations often can be identified first by one's peers more readily than by oneself. A decrease in staff performance, a lack of enthusiasm, an increase in defensiveness, criticism, and complaints are seen. These symptoms often lead to staff absenteeism, as the burned-out therapist's reaction is

discomforting and he/she begins to withdraw. This withdrawal poses a threat to the client as well as to the therapist. The caregiver can no longer care. The original nurturance and empathy disappear, leaving the therapist feeling helpless and hopeless. The therapist's creativity and resourcefulness diminish making it difficult for the staff member to maintain an adequate level of functioning.

Certain individual characteristics appear to heighten vulnerability to burnout among helping professionals. Those who are unwilling to recognize burnout and deal with it, or those who appear to be idealistic and unable to maintain some type of flexibility may find themselves prime candidates for burnout (Ansell, 1981).

Ansell believes there is a strong correlation between the symptoms of burnout and the effect they have on one's character. He lists in succession these symptoms:

1. Exhaustion, where one pushes oneself beyond his/her capacities. The individual has a difficult time accepting the feelings of fatigue and loss of energy;
2. In order to prevent rejection and pain, the therapist will detach himself/herself from

the situation or person that produces the hurt;

3. The individual becomes bored;
4. There is an intolerance of others and an increased irritability;
5. The therapist feels he/she is the only one able to perform a specific duty;
6. The therapist feels unappreciated;
7. Paranoid feelings develop;
8. There is a mental absenteeism, a lack of awareness of one's environment;
9. Psychosomatic complaints begin; and
10. Therapists become situationally depressed.

Job-Satisfaction

In a study conducted by Cherniss and Egnatios (1978), they found community mental health center staff were less satisfied with their work than other identified groups of workers. The major areas of stress identified in the role of job-dissatisfaction were: a) inadequate feelings around training; b) inadequate and at times lack of direct feedback around job responsibilities and activities; c) an increased amount of paperwork; and d) inadequate job descriptions, system changes and issues. These potential stressors may indeed effect how staff choose to cope. Low morale and absenteeism were suggested as a possible response.

Stress Response Model

Work stressors affect a therapist's response depending upon the individual's appraisal of the stressor. The appraisal process includes both affective and cognitive components. Burnout can be a maladaptive response to stressors. Increased rates of absenteeism can reflect burnout. Absenteeism is one variable which may be seen as an indicator of failure in coping and by inference, a sign of burnout.

Figure 1 illustrates a cognitive appraisal model of stress and coping. Moving from left to right, the process of work stress and response within the community mental health center is noted. Potential stressors include: a) the demands of the organization and workload; b) the amount of perceived organizational change; c) the types of clients; and d) the amount of therapist input into the system. The appraisal process is determined by two aspects: a) whether or not the appraisal is seen as a threat, harm or a challenge; and b) the characteristics of the individual, plus his/her coping and supportive resources. Adaptive or maladaptive responses occur as a result of the appraisal process. An adaptive response is more likely to occur in respose to a realistic appraisal of the stressor resulting in

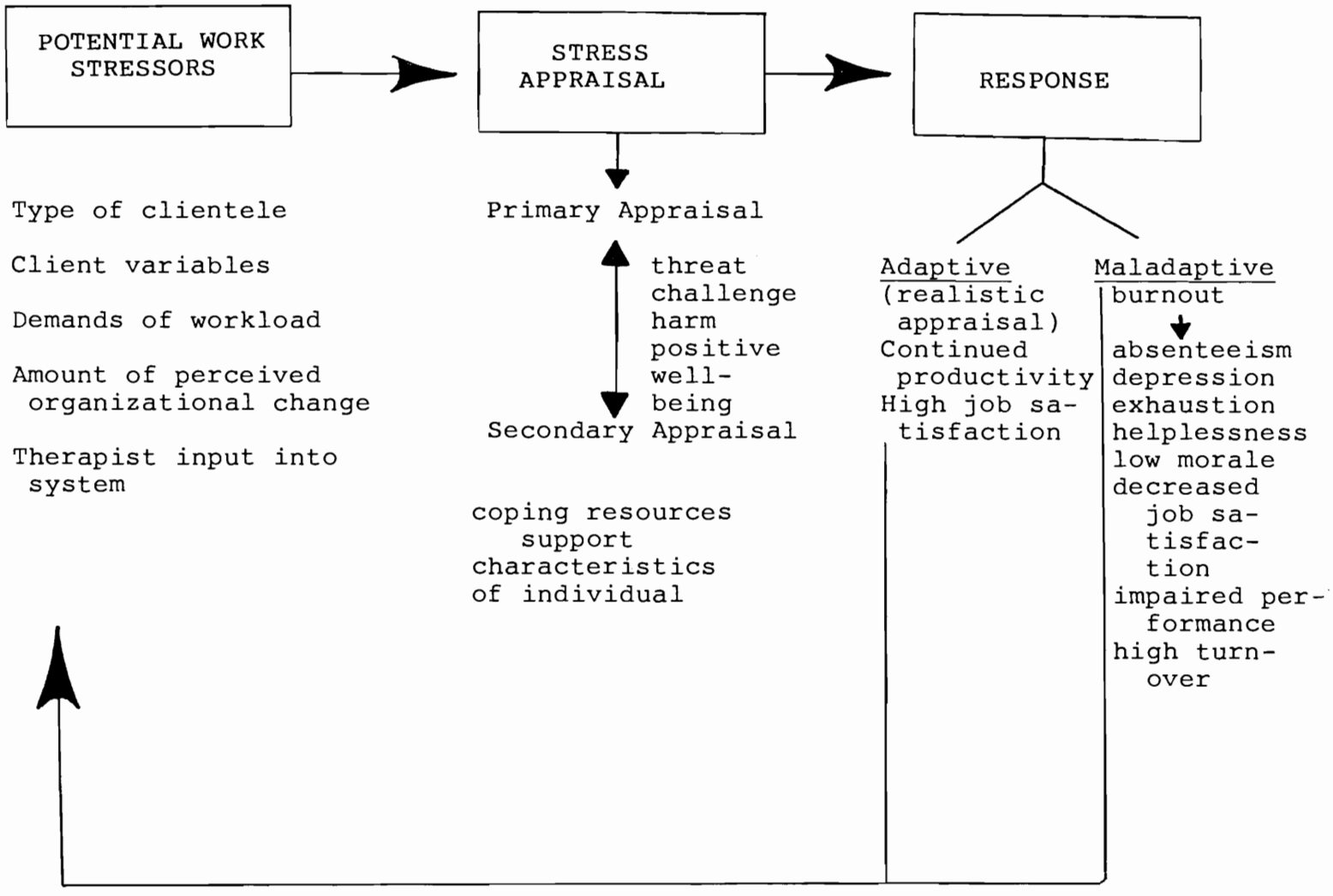

Figure 1. Stress-response model. Cognitive appraisal of job stress and burnout.

effective coping behaviors and in higher job-satisfaction and productivity. Distorted, unrealistic appraisals lead to maladaptive behaviors and responses like absenteeism, low morale, and job dissatisfaction A feedback loop is created as the response is then fed back to further impact the appraisal of the stressor(s), and the resulting coping response.

A specific model of stress and burnout as it relates to this study can be seen in Figure 2. In this model the work stressors involve the following assumptions based on previous research by Ansell (1981), Freudenberger (1977), Pines and Maslach (1978), and Scholom and Perlman (1979).

1. A chronic caseload where perceived improvement in clients is often minimal;
2. Lack of staff support and appreciation, both by peers, administration, and clients;
3. Lack of therapist input in terms of changes within the organization;
4. The uncertainty of how change will affect job satisfaction, location and the worker; and
5. Over involvement of administrators in line-staff meetings as opposed to having direct contact with clients.

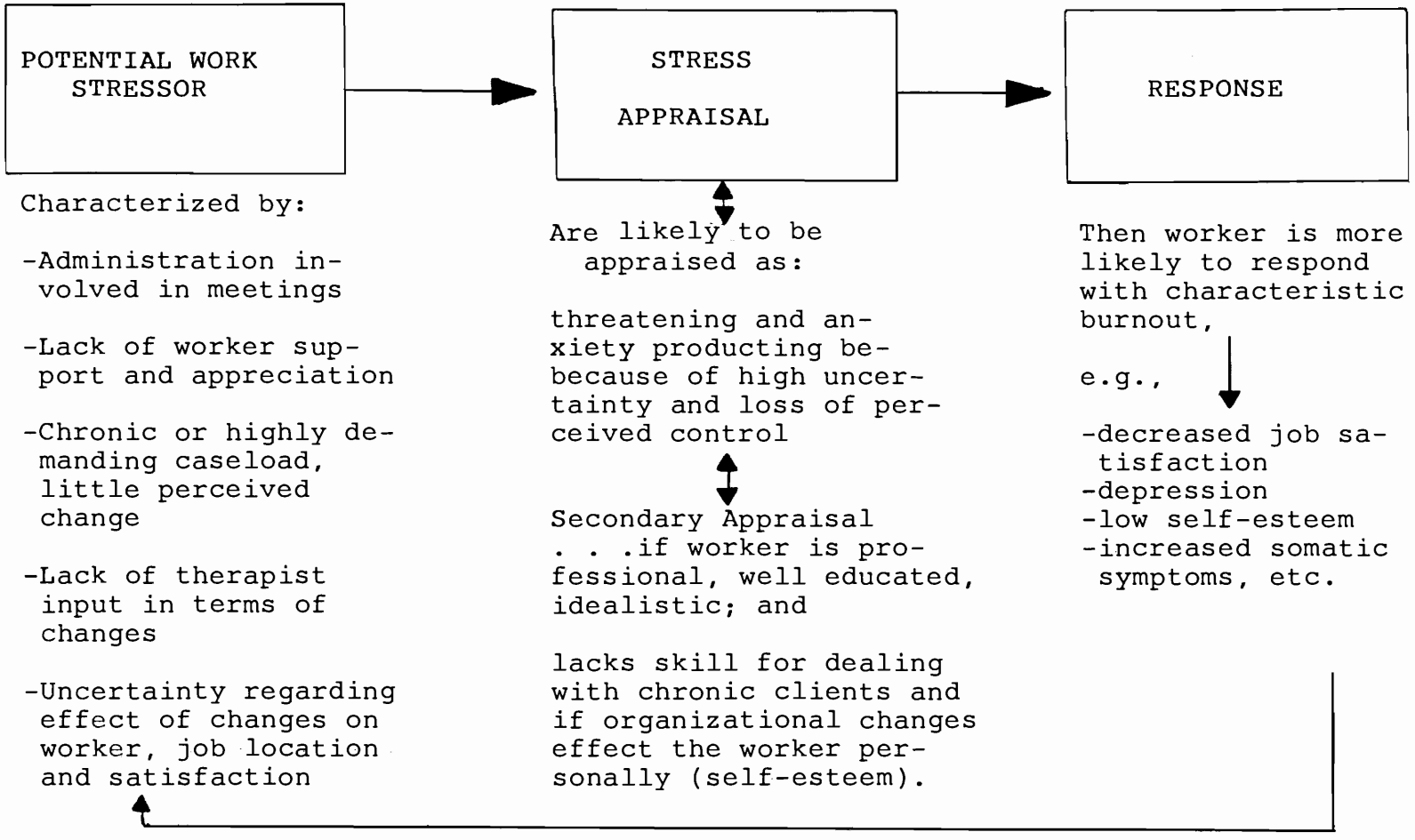

Figure 2. Conceptual framework for stress-response syndrome among staff who are vulnerable to burnout.

Presence of the above environmental conditions appears to enhance the likelihood of an individual perceiving a source of stress as threatening. In addition, if the worker lacks skill for dealing with chronic clients, or if organizational changes affect the worker on a personal level, a maladaptive response is more likely to occur. However, it is also apparent that for some individuals stressors act as challenges to be coped with rather than as upsetting events which heighten anxiety or feelings of helplessness.

Stressors which are characterized by high uncertainty or unpredictability and low perceived control either as a result of the nature of organizational changes or characteristics of client caseload, have a greater tendency to be experienced as stressful and to lead to burnout. If the worker adapts positively to the stressor(s) it is assumed he/she will be able to maintain sufficient flexibility, creativity and energy in order to cope with the given situation.

This model implies that the type and character of the individual mental health worker plays a significant part in how he/she may handle a stressful situation. It was assumed for example, that mental health workers vary in their preferences and training concerning the type of clientele with whom they prefer to

work. This distinction, along with how well one tolerates organizational ambiguity during times of change, was assumed would also play a significant role in the degree of perceived stress experienced. The type of client one staff person describes as being difficult to work with, may in fact be the type in which another staff person decides to specialize. The amount of stress experienced, therefore, is dependent to a large extent upon the interaction between the individual's perceptions, preparation, needs and motivation, supports within the system and the characteristics of the caseload and work demands.

Related Literature

During the last fifteen years as community mental health centers have become the primary treatment facilities for the more "severely ill client," burnout among staff members treating these clients has become a very common syndrome (Rubin, 1978; Scholom & Perlman, 1979). The movement toward deinstitutionalization placed in the community types of individuals previously seen as being treatable only in institutions. With the mandate of the Community Mental Health Centers Act of 1963, the burden to treat the more severely ill or chronic client in the community fell on administrators as well as staff. Therapists in some centers

began to experience an increase in levels of stress because of: a) apparent low priority by administrators or mental health centers in supporting treatment of the chronic mental patient; and b) the hiring of staff who were not trained or motivated to work with the chronic client. Hogarty (1971) and Zolick and Boyd (1972) suggested that negative attitudes toward this population by therapists is one reason for inadequate treatment of the chronic client. Rubin summarized Hogarty, Zolick and Boyd's study as follows:

> Partial explanation for the inadequacy of aftercare services may be found in the negative attitudes of mental health practitioners toward aftercare services. In contrast to more esoteric roles in psychotherapy or consultation, the provision for aftercare services may appear to be unimportant or unattractive to the highly professionalized practitioners (1978, p. 199).

Within the community mental health center organization one finds all of the components of any productive and successful business, plus the pressures of working closely with people in need. Often this contact with chronic patients continues for long periods of time. As with any organization, there are expectations like those named above, plus a need for record keeping, performance of numerous roles and most important of all to provide direct client care (Chermiss, 1978).

Pardes (1979) reported that in a given year

approximately fifteen percent of the American people will develop diagnosable mental disorders. These disorders are being treated more frequently in community settings, rather than in institutions. Many of the severely ill clients are unable to pay for their treatment making the private sector unavailable to them; therefore, community mental health centers provide for the majority of their treatment needs.

Maslach (1978) found that individuals who work within the helping professions, where direct personal contact is present over long periods of time, experience a level of stress which may result in emotional exhaustion or burnout. If burnout is not acknowledged and treated appropriately, staff may develop negative attitudes toward themselves, their job and no longer care for clients. In other words, those who function as primary caregivers and who are unable to make necessary adjustments may unwittingly find themselves actually harming clients rather than providing them with the help they may need.

Scholom and Perlman (1979) report that many administrators of mental health centers place little importance on the personal feelings of their staff. Energy is directed toward the external, service-oriented aspects of the center, such as psychotherapy, consul-

tation and evaluation. Often staff morale and job satisfaction are of secondary importance. Staff feel helpless, with a lack of control and input into the organization. Isolation of smaller units becomes a potential source of stress. Scholom and Perlman (1979) reported that staff need the support of the agency as well as recognition for treating and managing large caseloads of clients.

A number of investigators have identified types of clients treated in mental health centers which are likely to promote burnout among staff (Caton, 1981; Maslach, 1978; Schwartz & Goldfinger, 1981). Each client subtype described below contributed to burnout in a unique way. The characteristics of the worker's caseload most conducive to staff burnout include: a) caseloads of primarily younger clients never having been treated in institutions; b) caseloads of primarily older deinstitutionalized clients and nursing home clients; and c) caseloads with clients exhibiting neurotic and situational disorders, as well as some types of personality disorders. These latter types of clients are not commonly classified as the chronically mentally ill, but their problems may be chronic in nature. Often these latter individuals enter treatment with outpatient therapists

and are then transferred to therapists oriented toward long-term treatment. This group also includes clients with severe affective disorders, requiring medication evaluation, maintenance and long-term therapy. These chronically depressed individuals are maintained primarily by outpatient therapists and psychiatrists.

Rubin (1978) observed that most therapists prefer to work with clients who are intelligent, verbal, motivated and fairly healthy individuals. These individuals are more like the therapists themselves so there is a shared common ground. They feel more comfortable with them because they are easier to treat than clients with long-standing illnesses and severe personality disorders. Positive changes occur more readily with this type of client than with the chronically mentally ill who are frequently seen as "incurable."

A new chronic client is emerging in the community, the transient. They are most likely to be male, single, unemployed and between the ages of 18 and 35. They are often aggressive, manipulative and isolated with little or no support system. They lack appropriate reality testing, are frequently paranoid and have difficulty with impulse control. They are vulnerable to the effect of stress, have difficulty establishing

lasting relationships, fail to learn from past experience and experience repeated failures. Rarely do they exhibit the cognitive difficulties associated with schizophrenia (Pepper, Kirshner & Ryglewicz, 1981; Schwartz & Goldfinger, 1981), but they frequently confront the community with mental health "crises."

Caton (1981) describes another type of chronic client in the community. They are schizophrenics who first became ill after 1966 when the policy of deinstitutionalization went into effect. They exhibit poor treatment compliance, have high recidivism rates, poor social interactions and have need to be maintained on psychotropic medication.

In addition to types of clientele conducive to burnout in staff, the roles clients play may also increase the therapist's emotional stress to the point of producing burnout. These factors were outlined in detail by Maslach (1978). She concluded that the incidence of burnout increases when: a) staff are faced with many stressful interactions with clients on a consistent, prolonged basis; b) staff work long hours with clients like schizophrenics who require a maximum amount of effort and still show minimal progress; c) staff members over-identify with their client's problems. This inability to separate from

clients may affect the rate of burnout, particularly if it goes unrecognized by the therapist; and d) staff members begin to doubt their own skills due to a lack of positive strokes from the clients they are treating.

As to the role of the therapist, there is an expectation that the therapist will provide comfort and treatment. At the same time, a therapist must maintain a sense of distance while still maintaining concern for the client. If staff have difficulty maintaining this delicate balance, they begin to exhibit burnout symptoms.

Appelbaum (1980) noted that acquiring ways of managing stressful experiences is essential in order to reduce burnout. He observed that encountering stressors is inherent in the nature of organizations and if not handled appropriately the effects are costly and counterproductive. He suggested that even though individuals may appear to cope with stress at the psychological level, it may still be effecting them physiologically. One cannot see for example, hypertension, increased cholesterol and fatty substances in the bloodstream without laboratory studies. One cannot always assume the stress response does not exist simply on the basis of one's psychological appearance and/or performance.

What happens then: a) to the staff person who does burnout; b) to the organization with whom the staff person is identified; and c) to the client with whom the staff is working? Maslach (1978) suggested that the staff person who burns out is unable to deal successfully with the emotional stressors of the job. This failure to cope can be manifested in a number of different ways, including low morale, impaired performance, absenteeism, decreased job-satisfaction and high turnover.

Staff working with chronic clients are said to experience high burnout rates, yet the investigator had not directly observed this phenomenon within the mental health center system where the present investigation was conducted. The investigator was curious as to whether or not staff working with chronic clients in this center had acquired the necessary coping mechanisms in order to deal with change effectively. Included in these coping mechanisms would be: a) the therapist's individual makeup; b) his/her ability to draw upon an eclectic, rather than a more traditional method of psychotherapy for treating the chronically mentally ill; c) whether or not a therapist is able to conceptualize and understand the nature of chronic mental illness; and, d) whether or not the therapist

is willing to focus on minute changes over longer periods of time rather than on major changes in shorter periods of time. If therapists have been able to develop an appropriate therapeutic framework, then stressors like organizational change may not effect them in the same way that individual's without this framework may be effected.

The Salt Lake Community Mental Health Center had recently undergone a series of consolidation and cost containment efforts when the present study was undertaken. This experience of organizational change provided the opportunity for studying the differential effects of caseload (chronic versus nonchronic) upon perceived stress (amount of perceived change) and the occurrence of signs of burnout, particularly absenteeism in a natural setting. Absenteeism has been identified in numerous studies as an indicator of burnout and since records of absenteeism are readily available the investigator decided to use it as an indirect measure of burnout among mental health professionals (Margolis, Kroes & Quinn, 1974; Cherniss & Egnatios, 1978; Maslach, 1978; Pines & Maslach, 1978; Maslach & Jackson, 1979; Scholom & Perlman, 1979; Spaniol & Capunto, 1979; Appelbaum, 1980; Ansell, 1981; Wolfe, 1981; Schuler, 1982).

In summary, this study was based on research data which suggested therapists working in community mental health centers were dissatisfied with their jobs. It has also been observed that therapists working with types of clientele exhibiting chronic mental illness tended to be more vulnerable to experiencing burnout. While the majority of research relating to burnout and job related stresses of mental health workers has been carried out in institutional settings, the results have been generalized to outpatient settings as well. Whether or not rates of burnout are higher for therapists working with chronic clients in outpatient settings in comparison with those who have a difficult (more behavioral) outpatient caseload has not been systematically investigated.

Hypotheses

This study attempted to assess the following major hypotheses:

1. There will be a significant inverse correlation between the measure of job-satisfaction and absenteeism;
2. There will be significantly higher rates of perceived change (stress) in therapists with chronic caseloads as compared with therapists with nonchronic caseloads.

3. There will be a significantly higher rate in the burnout indicators (behavioral, [absenteeism] and self-report indices) for therapists who work with chronic clients than for those who work with nonchronic clients on both behavioral (absenteeism) and self-report indices.
4. There will be significantly higher burnout rates (on both behavioral [absenteeism] and self-report indices) among therapists who perceive higher change (degree and intensity) than among therapists who perceive low change.

CHAPTER II

METHOD

The Salt Lake County Division of Mental Health is a recently reorganized, decentralized comprehensive mental health center. The reorganizational changes in the center presented the naturalistic opportunity to assess the impact of differing amounts of change and resultant stress on mental health workers dealing primarily with either chronic or nonchronic populations.

Many of the individual units within this organization have two organized teams available to meet the needs of individuals applying for services. One team responds to the chronically mentally ill client, the long-term, multiproblemed client, and those needing medication. The second team, the outpatient team, provides treatment to individuals with more acute, situational types of problems. Even though there are two teams, there are therapists who work in both areas, primarily to add variety to their job description and to acquire new skills. Since subjects from the study were all

employees of the same mental health center, generalizability of these results to other settings is limited.

In order to answer the research questions, a questionnaire survey was designed which could be used to correlate perceived change (stress) and absenteeism along with other signs and symptoms of burnout. It was felt that a questionnaire assessment of worker stress, response and coping mechanisms coupled with objective absenteeism data analysis could provide the most valid and available data to examine this issue.

The questionnaire was used to identify employee's perceptions of burnout, job satisfaction, types of changes contributing to stress within a specific six month time frame, coping mechanisms and change. In addition, certain questions pertaining to demographic data were also included in the questionnaire.

Subjects and Setting

Seventy-four clinical staff members of the Salt Lake County Division of Mental Health volunteered for participation in the study out of eighty-five staff who heard the study presentation and were available for participation (87%).

The highly professional nature of the clinical staff is evidenced in the educational level of respon-

dents. Sixteen percent of the sample were nurses holding from associate to masters level degrees. Psychiatrists, masters level social workers and clinical psychologists made up 61% of the sample and 15% were paraprofessionals with bachelor degrees or less. Information describing years of experience with chronic and nonchronic client populations is contained in Table 1. Years of experience working with chronic populations ranged from 3.83 years for nurses to 11.36 years for psychiatrists. Mean years of experience with nonchronic populations ranged from 5.12 years for nurses to 11.36 years for psychiatrists.

Since the study was conducted in a natural setting, various compromises in research design and methodology were required to secure approval for the study to be conducted. These compromises had to do with maintaining confidentiality and limitations regarding the type of questions which could be asked on the questionnaire. To insure that subjects could respond anonymously, demographic information on subjects was limited to professional affiliation, years of experience, and the final four digits of the employees social security number. Assuring subjects of confidentiality was considered essential in order to improve validity. At the recommendation of the mental health research

Table 1

Number of Years Community Mental Health Staff Worked with Chronic and Nonchronic Clients and Type of Profession

Discipline	Number C[a]	Number NC[b]	Mean Years With C	SD	Mean Years With NC	SD
Total	64	54	6.70	5.78	8.33	5.98
Nurse	12	8	3.83	2.17	5.12	3.10
Psychiatrist	11	11	11.36	9.90	11.36	9.92
Psychologist	10	10	6.90	2.68	8.20	3.39
MSW	20	17	7.00	4.83	8.65	5.57
MHS[c]	11	8	4.45	3.04	6.88	2.47

Note. [a]C = chronic, [b]NC = nonchronic, [c]MHS = mental health specialist.

committee, other possibly identifying information (e.g., age, sex) was not collected. In this way, time deployment data could be obtained without any study materials containing subject names.

The Salt Lake County Division of Mental Health is responsible for providing various services to the County. It consists of six specialty units, five acute/intensive care units and six outpatient units. There are approximately 9,000 active cases currently being served by 350 staff. Approximately 40% of the active cases have chronic illnesses that are treated and maintained on an outpatient basis, with interim placements in the acute/intensive and/or specialty units.

The study was conducted in four outpatient units and two acute/intensive care units. The outpatient units serve the chronically mentally ill and non-chronic outpatient client populations and are located geographically within the county. The two acute/intensive care units are located in the north (urban) and south (suburban) areas of the county. They provide services primarily for identified chronic clients. Two outpatient units were newly organized and established units and therefore were not used. It was felt by the Salt Lake County Division of Mental

Health Research Committee that these two units would be inappropriate for the study because of the high level of change occurring at the time, thus affecting the data inappropriately.

Questionnaire

The tool used to measure employee perceptions of burnout, job satisfaction, types of changes contributing to stress and coping mechanisms was developed by the investigator based upon a review of the literature. A seven-point Likert scale was employed to measure attitudinal responses of the subjects (see Appendix A). The questionnaire consisted of seven basic sections and took approximately one-half hour to complete.

The first section measured general job satisfaction and perceptions pertaining to burnout. The questions in this section included such items as the ability to discuss and consult with coworkers and supervisors around job frustration, whether or not the worker felt secure with the job, whether or not he/she felt valued by the system, by peers and as part of an integrated team (Scholom & Perlman, 1979), and the amount of autonomy and variety of skills required in performing their job (Satata & Jeppesen, 1976). There were four items relating to burnout.

These items included questions about feeling burned out, and being exhausted or overextended (Maslach, 1978). As previously discussed, the incidence of burnout has been reported to increase in direct proportion to the number of chronic schizophrenic patients one has on his/her caseload as reported by Wolfe (1981).

Section two, an open-ended question, gave respondents the opportunity to report job stress items not anticipated by the investigator when constructing the questionnaire. The investigator was aware that this type of question would permit expression of feelings and possibly uncover unanticipated outcomes as well as validate items already included on the questionnaire (Henerson, Morris & Fitz-Gibbon, 1978). Responses to the open-ended questions were classified into fifteen categories representing the major types of stresses reported by the subjects. All judgments regarding coding of the responses into categories were made independently by two raters, the investigator and the chairman of the research committee for the County Division of Mental Health. Percentage of agreement was 85%. Coding disagreements were modified through consensus.

Section three asked respondents to check whether they had experienced any of eight types of change

during a six month period of time from June to December, 1981. This time period was one in which three administratively separate community mental health agencies consolidated into one administrative agency. If respondents experienced a change, they were asked to rate how stressful the experience was on a seven-point Likert scale. This question was patterned after a research questionnaire developed by Appelbaum (1980). He suggested that any type of change will effect an individual's level of fear, anxiety and stress. A change, whether viewed as positive or negative can have an effect upon the individual psychologically or physiologically. Examples of these items include: a) changes in physical location and type of clientele served; b) an increase in physical symptoms; c) increase in the amount of direct clinical care, record-keeping procedures or disagreements with treatment programs; and, d) a decrease in administrative and colleague support.

Section four asked respondents to check how frequently they used various mechanisms to cope with stress. A seven-point Likert scale was used to measure the responses. Coping mechanisms may be viewed in positive and negative terms. For example, if you refer back to Figure 2, a maladaptive response to

the appraisal of a stressor might be absenteeism. If a staff person were absent numerous times in a given period of time, services to the client and to the system may be interrupted. On the other hand, if a therapist decides he/she needs a vacation to reenergize, that may be viewed as a positive, adaptive way to deal with a stressor (Maslach, 1978; Pines & Maslach, 1978; Scholom & Perlman, 1979; Appelbaum, 1980; Ansell, 1981; Wolfe, 1981; Schuler, 1982). It was not the purpose of the questionnaire to sort out the positive and negative coping response, but to look at frequency.

Sections five and six made up part of the demographic material previously discussed (see Table 1).

Section seven asked respondents to check the response which best described changes in his/her expectations for client improvement since beginning employment. This question was included as a crude measure of idealism. Investigators report that individuals enter the health service system because they feel they can contribute to the well-being of other individuals. Often their attitudes and expectations are idealistic and not appropriate for the clientele with whom they work. Expectations for client improvement often change dramatically with job experience

(Maslach, 1978; White & Bennett, 1981; Wolfe, 1981).

Procedure

Following approval by the University of Utah Human Subjects Review Committee, the Salt Lake County Division of Mental Health Research Committee, and individual unit managers, 85 clinical staff members heard the research proposal presentation in one of the six units' regularly scheduled staff meetings. In this presentation the investigator explained the nature of the study, consent forms (Appendix B), and answered general questions. In agreeing to participate in the study, subjects completed the study questionnaire and gave consent to have absenteeism data collected from time deployment records. Questionnaires were completed during this staff meetings.

Absenteeism data were obtained from original time deployment records. In order to maintain confidentiality, only one member of the mental health center research team collected the data from archival sources. Both episodes and hours of absenteeism were recorded for a six month period of time when the three systems were undergoing the change of consolidation administratively.

Data Analysis

To test the hypotheses, a 2 by 2 between subjects analysis of variance was performed. This test of means was employed due to the small sample of the two independent groups.

Descriptive statistics were obtained for all questionnaire items of sections one through seven. In addition, in order to test for the strength of the association among the study variables, selected correlations were performed using the chi-square and the Pearson *r*.

In order to determine if staff members working with chronic clients were different from those working with nonchronic clients in terms of reported stress levels, absenteeism rates and job statisfaction, the staff were divided into chronic and nonchronic categories to differentiate their primary caseload based on their self-report of percent of time spent with each patient category. As a result of the establishment and consolidation of new outpatient units, there may have been some therapists shifted from the nonchronic area to the chronic area which may have affected reported stress, absenteeism rates and job satisfaction. The chronic and nonchronic categories were determined by whether or not the therapist spent 75%

or more of therapy time with either client category. This established one independent variable, the category for type of therapist. The limited therapist category consisted of staff members having worked less than 50 percent of their time providing therapy to chronic and/or nonchronic clients. The mixed caseload category consisted of staff members having 51 to 74% of their time providing therapy to the chronic and/or nonchronic client. Most of the data analyses were conducted utilizing the dichotomous typing of therapists according to chronic and nonchronic caseloads.

CHAPTER III

RESULTS

The sample selection was based on the therapists who signed the consent form, therefore allowing the collection of questionnaire and absenteeism data on 74 subjects. Of these, 23 (31%) were designated as therapists who worked with chronic clients, 18 (24%) were designated as therapists working with non-chronic clients, 23 (31%) had mixed caseloads, and 10 (14%) were in the limited therapist category. Descriptive and demographic data are presented on the entire subject sample, to check for internal consistency, then selected comparisons related to the study hypotheses between chronic and nonchronic therapist groups are made. Selected questionnaire items were analyzed to evaluate amounts of perceived change, job-satisfaction, and burnout. Absenteeism data were collected on all subjects to evaluate the relationship between an objective behavioral index of burnout (absenteeism) and self-reported (questionnaire) burnout.

Questionnaire items assessing perceived change

as a result of the system's reorganization were contained in section three of the questionnaire. Mean response values for this section are displayed in Table 2. This table validates that change had taken place, going back to the original assumption of change leading to the possible increase in stress. Items 3c and 3d asked subjects whether they had experienced major changes in client population or physical locale during the period of reorganization. Over 40% of the subjects reported major changes in one or both areas. This subgroup rated these changes as moderately stressful (4.70 and 4.34 on a 1-7 Likert scale). Other items assessed less obvious changes during this period. Seventy-seven percent of subjects reported increases in record keeping procedures which they found to be relatively quite stressful ($\underline{X}$ = 4.91). Thirty-nine percent of subjects polled reported decreases in administrative support during the reorganization. This type of change received the highest stress rating of all the items on the questionnaire ($\underline{X}$ = 5.41). Fifty-nine percent of subjects sampled reported increases in the demand for amounts of direct clinical care during the study period creating moderate stress ($\underline{X}$ = 4.86).

Section four of the questionnaire asked subjects

Table 2

Number, Percent, Mean and Standard Deviation for Type and Intensity of Change

	Type of Change	Reporting N	% of Total Sample	Change Intensity Mean	SD
a.	increase in record-keeping procedures	57	77	4.91	1.31
b.	increase in amount of direct clinical care	43	59	4.86	1.28
c.	change in client population with whom you treat	33	45	4.70	1.38
d.	change in physical location where you provide treatment	32	43	4.34	1.81
e.	decrease in administrative support	29	39	5.41	1.12
f.	increase in occurrence of health related symptoms	27	37	4.89	1.09
g.	decrease in colleague support	18	25	4.94	1.31
h.	increase in disagreement with superiors concerning appropriate treatment programs	11	15	4.73	1.35

Note. Change intensity ranged from 1, not at all stressful to 7, very stressful.

to report which sort of coping mechanisms they tended to use in coping with job stress. Table 3 displays responses to these items ordered by frequency. As can be seen from the table, talking with other staff or supervisors or taking vacation time were the most frequently reported stress coping mechanisms while going into personal therapy, being absent or volunteering for other kinds of work were the least frequently reported mechanisms.

Categorized responses to the open-ended questionnaire item "What do you experience as stressful in your job?" are contained in Table 4. A total of 175 codable responses was obtained and a content analysis was performed. While some therapists chose not to respond to this item a number cited areas of stress for the overall sample were characteristics of client caseload, pressure for direct clinical care, problems with administration, record-keeping problems, and inadequate resources.

Some differences in the pattern of responses based on therapist type were revealed. Responses pertaining to pressure for direct clinical care were frequent for all groups. Therapists which chronic or mixed caseloads tended to describe caseload characteristics as a major stressor more often than any

Table 3

Self-Reported Job Stress

Coping Mechanisms

	Coping Mechanisms	N	Mean	SD
a.	talking with another staff member	74	5.89	1.08
b.	talking with supervisor	74	4.68	1.84
c.	taking vacation time	74	3.99	1.65
d.	leaving unit and taking break	74	3.74	1.63
e.	thinking about changing jobs	72	3.72	1.70
f.	taking long lunch hours	74	3.05	1.76
g.	catching up on case records	72	2.90	1.65
h.	going into therapy yourself	73	2.67	1.87
i.	by being absent	74	2.16	1.19
j.	volunteering for other kinds of work	73	2.01	1.13
k.	other	12	5.50	1.24

Note. Coping mechanisms were reported using a 7-point scale, 1 indicating the coping mechanism was never used, 7 indicating frequently used.

Table 4

Percentage of Items Rated as Stressful by Type of Caseload

Area of Stress	Nonchr	Chr	Mixed	N
a. Characteristics of caseload	7.6%	30.7%	29.5%	37
b. Pressure for direct clinical care	19.2%	18.4%	22.7%	34
c. Problems with administration	5.7%	4.1%	15.9%	18
d. Problems with record-keeping	17.3%	8.2%	9.1%	17
e. Inadequate resources	5.7%	16.3%	6.8%	14
f. Problems with system communication	5.7%	4.1%	2.3%	7
g. Lack of supervision/training/ consultation	9.6%	2.0%	0.0%	7
h. No response/none	7.6%	2.0%	0.0%	7
i. Interpersonal conflict/differences within unit	1.9%	2.0%	6.8%	6
j. Lack of role definition/role conflict	7.6%	0.0%	2.3%	6
k. Inequitable reward for work	3.8%	6.1%	0.0%	5
l. Problems in other systems	1.9%	2.0%	0.0%	4
m. Job insecurity	0.0%	0.0%	6.8%	3
n. Quantity more important than quality	3.8%	0.0%	2.3%	3
o. Other	1.9%	2.0%	2.3%	4

Note. All judgments were independently made by two raters. Percentage of agreement was 85%. Coding disagreements were modified through consensus.

other type of stress. Relatively few nonchronic therapist responses cited this stressor. Instead, therapists working in nonchronic areas tended to report record-keeping requirements and lack of supervision as stressful most frequently, while these responses were relatively rare among chronic and mixed caseload therapists.

Table 5 contains rank ordered responses to job satisfaction and burnout items. Subjects rated their agreement with various statements on a 1 (strongly disagree) to 7 (strongly agree) scale. Therapists most strogly enjoyed the ability to utilize a variety of skills in their jobs, the opportunity to function autonomously and working on an integrated team. They expressed lowest satisfaction with the appropriateness of pay levels, system responsiveness, and the emphasis being placed on quantity as opposed to quality of patient care.

Section seven of the questionnaire asked subjects about changes in their expectations for client change since starting work. Table 6 displays response frequencies for the total sample as well as the chronic and nonchronic subgroups. Forty-nine percent of the total sample reported some drop in expectations of client change since starting work in the field,

Table 5

Number, Means and Standard Deviations for Job-Satisfaction and Burnout Items on Job Stress Questionnaire

	Job-Satisfaction Items	N	Mean	SD
d.	Can use a number of different skills in performing my job	74	6.26	1.05
e.	Can function autonomously	74	6.04	1.29
c.	Can work as part of an integrated team	74	6.01	1.21
b.	Can discuss job frustrations with my coworker	74	5.97	1.78
f.	Have the opportunity to get consultation and supervision when I need it	74	5.82	1.50
r.	Job is very important in lives of others	74	5.62	1.16
p.	Feel others value my expertise	74	5.60	.98
a.	Can discuss job frustrations with my supervisor	74	5.55	1.78
o.	Have flexibility to work with a variety of client populations in my job	74	5.54	1.42
q.	Feel good about the amount of constructive change I see in my clients	73	5.40	1.32
k.	Feel valuable to the system	74	5.34	1.42
n.	Have opportunity to learn new skills	74	5.24	1.27

Table 5 Continued

	Job-Satisfaction Items	N	Mean	SD
t.	Feel unit would be responsive to me in an attempt to initiate change	74	5.05	1.60
l.	Have job security and can count on my job	74	4.72	1.77
u.	Feel mental health system emphasizes quality of client care over quantity	74	3.81	1.70
s.	Feel system would be responsive to me in an attempt to initiate change	74	3.76	1.57
m.	Pay is appropriate for the responsibility I have	74	3.41	1.75
Burnout Items				
i.	Feel emotionally up-lifted with the work I do [a,b]	73	4.92	1.39
j.	Feel physically exhausted by the end of the day	74	4.43	1.67
g.	Can handle all of my responsibilities [a]	74	4.20	1.54
h.	Feel burned out	74	3.54	1.56

Note. The job satisfaction items and burnout items ranged from 1, strongly disagree to 7, strongly agree.

a These items were reverse coded for statistical analysis

b Item i was removed from the summartive burnout variables due to low internal consistency

Table 6

Percent of Expected Client Improvement

by Chronic and Nonchronic Caseload

	Statement	Total %	C %[a]	NC %[b]
a.	Expect much less client improvement than I used to	18	39.1	11.1
b.	Expect somewhat less client improvement than I used to	31	21.7	16.7
c.	Expect same client improvement I used to	24	17.4	44.4
d.	Expect somewhat more client improvement than I used to	33	17.4	22.2
e.	Expect much more client improvement than I used to	4	4.4	5.6
	N Total	71	22	17

Note. [a] chronic, [b] nonchronic.

while 27 percent reported that their expectations of client improvement had risen. Twenty-four percent described their expectations as unchanged. Thirty-nine percent of therapists working with chronic clients expected less client improvement as opposed to 11 percent for therapists working with nonchronic clients.

Hypothesis One

A major study hypothesis predicted a significant inverse correlation between job-satisfaction and absenteeism. Pearson product-moment correlation coefficients were calculated to assess this relationship. A moderate and statistically significant correlation coefficient between job-satisfaction ratings and episodes of absenteeism was obtained (r = -.368, $p < .01$, n = 70). The relationship between job-satisfaction and hours of absenteeism suggested a trend in the predicted direction (r = -.204, $p < .10$, n = 68).

Group Differences: Hypotheses Two, Three and Four

Hypothesis Two

The major focus of this study was to assess possible differential effects of stress and organizational change on two major therapist groups; therapists with

primarily chronic caseloads and therapists with primarily nonchronic caseloads. It was hypothesized that these groups would perceive change differently and show differing burnout rates based on self-report and behavioral (absenteeism) data. It was further hypothesized that therapists reporting high amounts of change would demonstrate behavioral and self-report effects of more burnout than subjects experiencing low change.

Tables 7 and 8 display data involving total number of reported changes and changes weighted by intensity respectively. There were no significant differences between chronic and nonchronic therapist groups on either total number of changes reported ($F(1,39)$ 1.00, $p \not< .10$) or weighted change variables ($F(1,39)$ $\not< 1.00$, $p \not< .10$) (See Appendix C) (Summary tables for all ANOVAs are contained in Appendix C).

Hypothesis Three

Number, means and standard deviations for the behavioral index and absenteeism are contained in Table 9. Results of the ANOVA indicated no significant differences between therapist groups for either the episodes (F $(1.34 < 1.00$, $p > .10)$ or the total hours of absenteeism variables (F $(1.33) < 1.00$, $p > .10$)(See Appendix C).

Table 7

Means and Standard Deviations for Number of Changes Reported by Therapists of Chronic and Nonchronic Caseloads

	N	Mean	SD
Total Sample	74	3.38	1.83
Chronic	23	3.26	1.51
Nonchronic	18	3.78	2.05

Table 8

Means, Standard Deviations on Weighted Sum of Changes Reported by Therapists

	N	Mean	SD
Total Sample	74	16.18	10.28
Chronic	23	15.57	8.78
Nonchronic	18	18.39	12.09

Table 9

Means and Standard Deviations of Absenteeism Episodes and Hours for Total Sample and by Type of Caseload

	Episodes			Hours		
	N	Mean	SD	N	Mean	SD
Total Sample	70	2.60	3.07	68	16.88	18.64
Chronic	21	2.62	2.85	21	17.05	17.88
Nonchronic	17	3.12	3.84	16	19.00	20.62

The questionnaire contained four items (items g, h, i, j) (see Table 5) specifically designed to assess the degree of burnout experienced by the subjects. Item i was deleted from the analysis since internal consistency among items was low with the item included (α = .56) and appropriately high with its exclusion (α = .68). Of the remaining three items, item g was reverse coded so that a summation measure of self-reported burnout could be constructed. Summed scores for the three remaining items constituted the Burnout Index. These data are presented in Table 10. No significant differences were found between therapist groups on the Burnout Index ($F(1,37) < 1.00$, $p > .10$) (See Appendix C).

Hypothesis Four

It was expected that subjects experiencing high amounts of change due to the system reorganization would demonstrate more absenteeism and higher self-reported burnout than subjects experiencing lower amounts of change. Study subjects were assigned to either high change or low change categories based on their responses to questionnaire items 3a through 3h (see Table 2). These items asked subjects to report whether they had experienced any of eight types of change during the reorganization, and if so, to rate

Table 10

Means and Standard Deviations on Self Report of Burnout Index[a] for Total Sample and Type of Caseload

	N	Mean	SD
Total Sample	74	12.09	3.81
Chronic	23	11.91	3.20
Nonchronic	18	12.50	4.63

Note. [a]Burnout Index = Summed scores for questionnaire items g, h, j, with g reverse coded.

stressfulness of that change on a seven-point scale. The sum of their ratings on these eight items constituted the weighted change measure. Descriptive statistics for weighted change were: mean = 16.18, median = 15.00, standard deviation, 10.28, n = 74. A median split on the weighted change divided subjects into high and low change. Absenteeism and self reported burnout data are contained in Tables 11 and 12. No significant difference was detected between high and low change groups on either episodes ($F(1,34) = 1.784$, $p \not< .10$) or hours ($F(1,33 < 1.00$, $p \not< .10$) of absenteeism (see Appendix C).

Level of change was a significant factor in the Burnout Index ($F(1,37) = 5.88$, $p > .020$) (see Appendix C). As Table 12 demonstrates, persons experiencing low levels of change reported lower burnout than those reporting high levels of change.

Additional Findings

On a post hoc basis, an attempt was made to assess the interaction between response to change and therapist type on burnout indicators. Table 13 contains absenteeism data broken down by therapist type and amount of reported change. No significant interaction between change and therapist type was obtained for either episodes ($F(1,34) < 1.00$, $p \not< .10$) or hours

Table 11

Numbers and Means of Absenteeism Episodes and Hours Based on Amount of Reported Change

	Episodes		Hours	
	N	Mean	N	Mean
High Change	20	3.32	20	17.20
Low Change	18	2.05	17	18.70
Total	38	2.84	37	17.89

Table 12

Number and Means of the Burnout Index Based on Amount of Reported Change

	N	Mean
High Change	21	13.48
Low Change	20	10.80
Total	41	12.17

Table 13

Numbers, Means, and Standard Deviations of Absenteeism, Perceived Change, and Therapist Type

	Episodes			Hours		
	N	Mean	SD	N	Mean	SD
Low Change						
Nonchronic	7	2.14	2.41	6	24.33	29.73
Chronic	11	2.00	1.67	11	15.44	12.78
High Change						
Nonchronic	10	3.80	4.59	10	15.80	13.68
Chronic	10	3.30	3.74	10	18.60	22.88

of absenteeism ($F(1,33) < 1.00$, $p > .10$) (see Appendix C).

Table 14 contains similar data with respect to the Burnout Index. A significant interaction between change and therapist type was found for the Burnout Index ($F(1,37) = 5.762$, $p < .022$) (see Appendix C). These data are graphically represented in Figure 3. As the figure shows, therapists with chronic caseloads tended to obtain moderate burnout scores whether under conditions of high or low change. Therapists with nonchronic caseloads showed marked and significant increases in self-reported burnout under conditions of high change. These findings must be interpreted with caution because of the post hoc nature of the analysis and relatively small sample size.

Differences between therapist groups with regard to changes in expectations of client improvement were also evaluated on a post hoc basis. These data are displayed in Table 2. As noted in the table, 60.8% of therapists with chronic caseloads reported some decrease in their expectations for improvement while only 27.8% of therapists with nonchronic caseloads reported such a drop. For further analysis, subjects were divided according to those experiencing a drop in expectations and those experiencing unchanging or

Table 14

Numbers, Means, and Standard Deviations of Self-Reported Burnout, Perceived Change and Therapist Type

	N	Mean	SD
Low Change			
Nonchronic	8	9.38	4.50
Chronic	12	11.75	2.80
High Change			
Nonchronic	10	15.00	3.02
Chronic	11	12.09	3.73

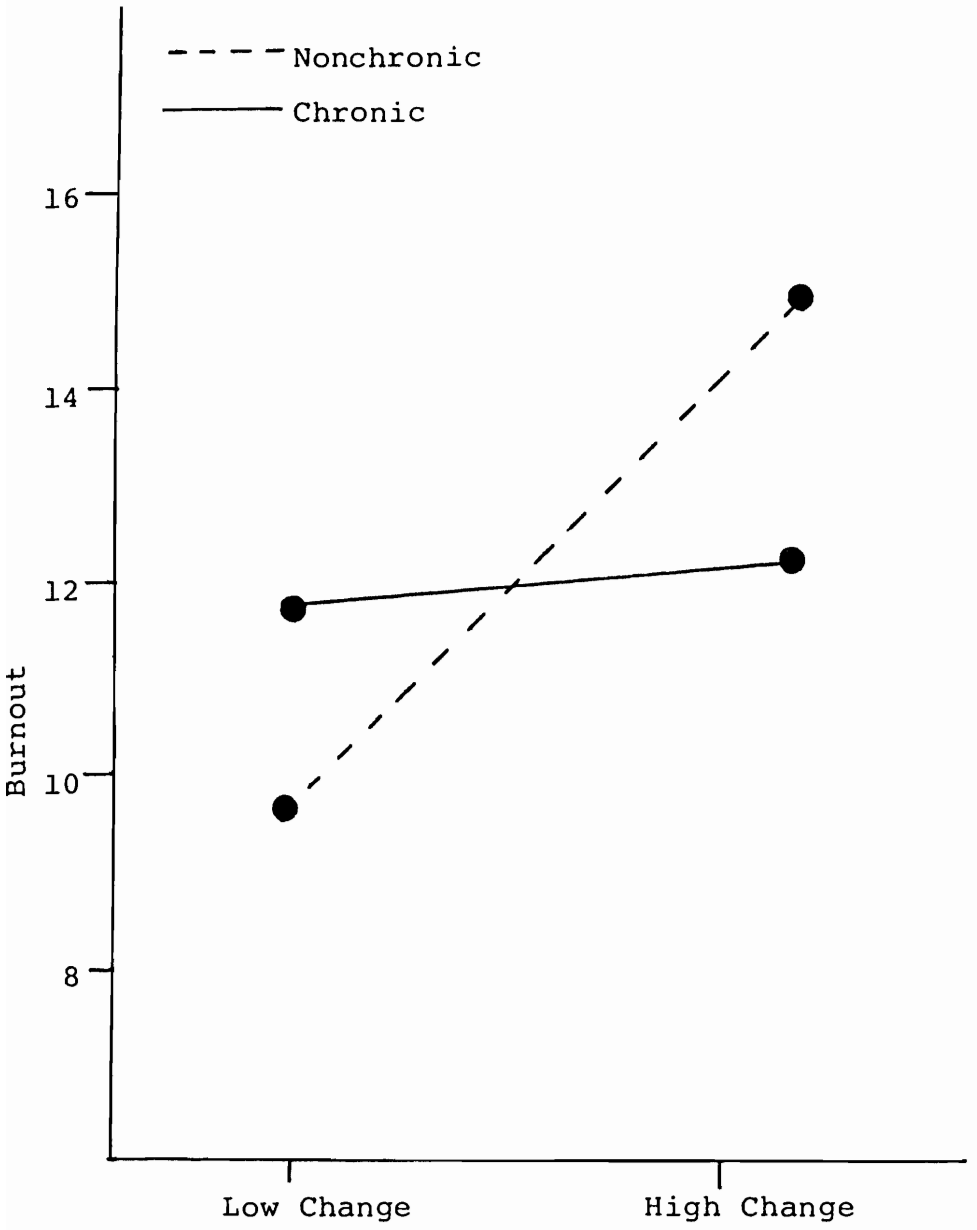

Figure 3. Interaction with therapist case-load and low versus high change on burnout ($\underline{N}$ =41). Higher numbers represent greater burnout.

improving expectations. These data are presented in Table 15. A chi-square analysis performed on these data revealed a significant difference in change of expectations based on therapist caseload ($\underline{X}^2 = 4.49$, $\underline{p} < .05$.

Validity Assessment

In order to assess the validity of various measures utilized in the study, a correlation matrix displaying interrelationships among study measures was constructed and is displayed in Table 16. A number of the relationships presented in the table warrant discussion. As previously noted, job satisfaction tended to be inversely related to both episodes ($\underline{r} = -.368$, $\underline{p} < .01$) and hours ($\underline{r} = -.204$, $\underline{p} < .10$) absenteeism. A similar inverse relationship between job-satisfaction and the Burnout Index was revealed ($\underline{r} = -.378$, $\underline{p} \leq .001$, $\underline{n} = 74$). Burnout and absenteeism indicators do not show a significant correlation, suggesting that these two indices may be assessing different and perhaps somewhat unrelated aspects of the response to stress. The Burnout Index is significantly and positively related to measures of reported change, both in terms of number of changes ($\underline{F} = .389$, $\underline{p} < .001$) and weighted changes ($\underline{r} = .399$, $\underline{p} < .001$), suggesting a positive relationship between self-reported

Table 15

Changes in Expectation of Improvement

Based on Therapist Type

	Expectations of Client Improvement		
	Less (N)	Same or More (N)	Total
Chronic (N)	14	5	19
Nonchronic (N)	8	12	20
Total	22	17	39

Note. $X^2 = 4.49$, $p < .05$.

Table 16

Descriptive Statistics and Intercorrelations of

Survey Responses and Absenteeism

	Burnout 1	Satisfaction 2	n Change 3	Wtd. Change 4	Abs. Epi. 5	Abs. Hrs. 6
a. Burnout[a]	1.00					
b. Satisfaction[b]	-3.78***	1.00				
c. Number Changes	.389***	-3.97*	1.00			
d. Wtd. Change	.399***	-.408****	.943****	1.00		
e. Absent: Epi	.157	-.368***	.210*	172	1.00	
f. Absent: Hrs.	.107	-.204**	.142	.080	.754[f]	1.00
Number Nonmissing	74	74	74	74	70	68
Mean	12.09	89.14	3.38	16.18	2.60	16.88
Standard Deviation	3.81	13.78	1.83	10.28	3.07	18.64

Note. [a]Number of items = 3, alpha coefficient = .680

[b]Number of items = 17, alpha coefficient = .867

*p < .10; **p < .05; ***p < .01; ****p < .001

burnout and self-reported change. In addition, the number and weight of the change indices were negatively correlated with job satisfaction levels to a significant degree, as might be expected from a review of the literature (r = -.397, $p < .001$; r = -.408, $p < .001$). To summarize the above noted relationships, it appears that both the self-report index of burnout (Burnout Index) and the absenteeism (Behavioral Index) show significant correlations with satisfaction and change indices. The fact that these two indicators do not show strong relationship with one another in this sample suggests that they may be assessing orthogonal components of response to stress.

CHAPTER IV

DISCUSSION

This study examined a number of predictions and assumptions derived from the growing literature on the stress related phenomena of burnout among mental health professionals. These issues were examined by assessing stress response, job-satisfaction and perceived change in a community mental health center undergoing a period of drastic administrative change and increased demands for services. Over 40% of the subjects sampled reported moderately stressful changes in physical location, client population, demand for service, and record-keeping. During this period, the most highly stressful change assessed, appeared to be decreases in administrative support reported by 39% of the sample. Clearly a significant proportion of the study sample was experiencing the stressful effects of the foregoing changes. This organizational change provided the opportunity to evaluate stress response variables during a period when staff stress had been realistically increased by a series of

practical as well as administrative changes.

The predicted inverse relationship between burnout measures and job satisfaction measures was confirmed (r = -.378, $p < .001$, N = 74). A moderate correlation between self-reported job-satisfaction and episodes of unscheduled absenteeism was obtained (r = -.368, $p < .01$, N = 74) (see Table 16). In addition, a similar relationship was found between job-satisfaction and self-reports of feeling burned out, over extended and physically exhausted by the end of the day. Such relationships between these variables had been predicted by a number of authors (Ansell, 1981; Maslach, 1978; Pines & Maslach, 1978; Rubin, 1978; Wolfe, 1981). It is notable as well, that subjects in the present sample reported satisfaction with a number of factors which have been suggested as possible countermeasures to burnout including the opportunity to function autonomously, utilize a variety of job skills and share responsibility in an integrated team. Such opportunities may serve to some degree to prevent or mediate against the effects of stress and burnout.

Examining sources of stress on the job can be an important first step in stress reduction and prevention of maladaptive responses. Subjects in the present study appeared to be experiencing a number

of job related stressors. A majority of subjects tested reported high pressure for direct clinical care to be a major source of job stress. One major change which took place during reorganization was implementation of job description standards requiring each therapist to provide a specific amount of direct clinical care. It appears this requirement was probably the result of administrative changes as well as a reduction in force which took place as part of the reorganization and which left fewer therapists in the system to deal with concommitantly rising service demands.

Subjects carrying chronic and mixed caseloads also reported that characteristics of those caseloads were a major stressor. Researchers have noted that responses to stress are more likely to be maladaptive if the stress sources are unrecognized or denied (Ansell, 1981; Wolfe, 1981). Therapists with mixed and chronic caseloads appear to be well aware of the stress resulting from their type of caseload, and therefore may be less likely to demonstrate maladaptive responses to this recognized source of stress, than if it had gone unrecognized. Problems resulting from increases in record-keeping demands and decreasing administrative support were also frequently noted

job stressors. Both of these stressors appear directly related to the reorganizational changes that had just taken place. A major focus of the reorganization had been implementation of uniform centerwide standards for record-keeping which had resulted in significant technical changes for a majority of therapists in the center.

Another important component of most models of burnout involves the availability and flexible integration of a number of coping mechanisms (Ansell, 1981; Freudenberger & Richelson, 1980). Therapists in the mental health center frequently report utilization of a number of adaptive stress management responses. Of these, talking with significant others and taking occasional vacation time were the most frequently cited. According to therapists' self-report, absenteeism was a seldom used coping response, ranking well below other options in frequency of reported use. The availability and utilization of these varied coping responses probably serves to some degree to reduce serious maladaptive responses (Ansell, 1981).

Another frequently cited component contributing to increased burnout is inflexibility of expectations of clients improvement (Ansell, 1981; Scholom & Perlman,

1979). Therapists in this study carrying chronic caseloads reported significant decreases in their expectations of client improvement since they started work. While some have suggested that such changes may result in poorer quality of patient care (Hogarty, 1971; Zolick & Boyd, 1972), others have argued that realistic reassessment of expectations regarding client improvement is an important factor in averting and preventing burnout (Ansell, 1981). While it is beyond the scope of this study to substantively resolve this area of controversy, it is important to note that such changes apparently do occur among therapists working in community mental health settings with chronic caseloads. Formal inclusion of information around the issue of expectations for client improvement as it relates to various diagnostic categories in training programs would probably serve to decrease chances of burnout. Further research in this area would clearly be helpful.

Predictions of group differences between therapists with chronic and nonchronic caseloads on variables involving perceived change, absenteeism, and self-reported burnout were largely unsupported by the present findings. These predictions were based on the work of Wolfe (1981) and Pines and Maslach

(1981) who proposed that burnout increases in proportion to the number of chronic schizophrenics on one's caseload. The results of this study do not support these conclusions. A number of factors may have contributed to these results. These predictions stemmed primarily from work in institutional settings where there is prolonged contact with clients, unlike outpatient settings; hence, it is probably not valid to generalize results from inpatient to community based settings. It may be that counter-burnout measures as noted above provided sufficient aid so as to avert or substantially decrease burnout rates. Another possibility is that no differences between therapists with chronic and nonchronic caseloads were found because each group responds with equal stress to different sorts of stressors in their jobs. The differences in reported patterns of stress according to caseload support this possibility. Another possible explanation is that the measures utilized did not really measure the changes anticipated. The measures also may not have been appropriately sensitive relative to the variables the investigator wished to examine.

The correlation matrix (see Table 16) shows that self-reports of burnout were significantly correlated

with measures of job-satisfaction and change. This means individuals reporting high burnout tended to have lower job-satisfaction and a higher perceived incidence of change. One should not conclude that there exists a cause and effect relationship based only on a significant correlation.

Absenteeism and job-satisfaction demonstrated the predicted relationship; however, absenteeism was only minutely related to the change measure in this study. One possible explanation of this finding is that absenteeism may be a poor behavioral measure of burnout, because many factors, besides job related burnout, can cause absences, such as family emergencies, long illness, maternity leaves, etc. Absenteeism may also be the end stage of burnout, a final coping mechanism to accumulated stressors. In this way, absenteeism may be contaminated by too many other factors to be a good measure. Ansell (1981) mentions the possibility that absenteeism may be more "mental absenteeism" than actual absenteeism. Future investigators may want to use other indirect measures than absenteeism to assess burnout. Appelbaum (1980) suggests the interesting possibility of using physiological measures like hypertension or cholesterol levels to measure burnout. It may also be that therapists in the

system have enough other coping options in the system so as not to have to resort to being absent to cope with high stress levels. Absenteeism may also have been reduced by fears about job security.

The post hoc finding (Figure 3) was exploratory in nature, to see if the results would be of help in explaining the data. A significant interaction found more burnout with therapists of nonchronic caseloads than therapists of chronic caseloads in situations of high change. For therapists of chronic caseloads, burnout does not vary according to low change or high change.

Referring back to the model of stress and burnout as seen in Figure 2, a stressor is appraised as threatening or nonthreatening. For therapists of nonchronic caseloads, the stressor, organizational change appeared to be viewed as threatening, suggesting the possibility of burnout. This did not seem to be the case for therapists of chronic caseloads. The investigator's assumption was that there would be a relationship between change, burnout and absenteeism. There was a significant correlation at the $p < .001$ level (.399) between change and burnout but not between burnout and absenteeism (see Table 16). High change was related to higher burnout, but higher burnout

was not related to higher absenteeism. Therefore, absenteeism may not be the relevant maladaptive response of this interaction. One of the other maladaptive responses may be more predictive of burnout.

Type of therapist caseload, did not seem to affect perceived change or absenteeism levels and levels of change did not affect absenteeism levels. However, high levels of job satisfaction were related to low levels of absenteeism. Absenteeism may be more directly correlated with job satisfaction than with burnout. Type of caseload, whether it be chronic or nonchronic did not appear to be as important in predicting perceptions of organizational change and absenteeism as had been anticipated.

Suggestions for Further Research

Mental health centers seem to be designed differently than inpatient settings and therefore need to be studied thoroughly. Outpatient centers have different missions thus displaying a need to study effects of different types of stress. An attempt to evaluate what differences, if any, there might be between the stress-response syndrome of staff in inpatient settings as opposed to staff in outpatient settings could only enhance the work environment as well as the therapeutic regime. Different stressors require different

coping responses.

Another area where research may be helpful relates to the nature of the integrated team. One might want to look at the strengths and weaknesses related to the team concept particularly as they relate to those teams working with chronic clients as opposed to nonchronic clients.

An investigator may want to address staff members' absenteeism rates over time. A longitudinal study would be appropriate in order to examine the question, would individual staff members be absent less if they were more satisfied?

In general, surveying a mental health system as a whole entity rather than dividing it up between staff working with chronic clients or those working with nonchronic clients may prove most beneficial. Information regarding how to reduce stress and maximize coping should have benefits for administrators, therapists and clients alike.

APPENDIX A

JOB STRESS QUESTIONNAIRE

Last 4 digits of SS #. _ _ _ _

When you have completed the questionnaire, please place it in the envelope provided and return it to the person identified prior to handing out the questionnaire.

---

1. How much do you agree or disagree with the following statements? (Circle a number on the scale that accompanies each statement).	Strongly disagree			Neutral			Strongly agree
a. I feel I can discuss job frustrations with my supervisor.	1	2	3	4	5	6	7
b. I feel I can discuss job frustrations with my coworkers.	1	2	3	4	5	6	7
c. I feel I can work as part of an integrated team.	1	2	3	4	5	6	7
d. I feel I can use a number of different skills in performing my job.	1	2	3	4	5	6	7
e. I feel I can function autonomously.	1	2	3	4	5	6	7
f. I feel I have the opportunity to get consultation and supervision when I need it.	1	2	3	4	5	6	7
g. I feel I can handle all of my responsibilities without overextending myself.	1	2	3	4	5	6	7
h. I feel burned out.	1	2	3	4	5	6	7
i. I feel emotionally uplifted with the work I do.	1	2	3	4	5	6	7

		Strongly disagree			Neutral			Strongly agree
j.	I feel physically exhausted by the end of the day.	1	2	3	4	5	6	7
k.	I feel valuable to the system.	1	2	3	4	5	6	7
l.	I feel I have job security and can count on my job.	1	2	3	4	5	6	7
m.	I feel my pay is appropriate for the responsibilities I have.	1	2	3	4	5	6	7
n.	I have the opportunity to learn new skills in my job.	1	2	3	4	5	6	7
o.	I have the flexibility to work with a variety of client populations in my job.	1	2	3	4	5	6	7
p.	I feel others value my expertise.	1	2	3	4	5	6	7
q.	I feel good about the amount of constructive change I see in my clients.	1	2	3	4	5	6	7
r.	My job is very important in the lives of other people.	1	2	3	4	5	6	7
s.	I feel the system would be responsive to me in an attempt to initiate change.	1	2	3	4	5	6	7
t.	I feel my unit would be responsive to me in an attempt to initiate change.	1	2	3	4	5	6	7
u.	I feel the mental health system emphasizes quality of client care over quantity.	1	2	3	4	5	6	7

2. What do you experience as stressful in your job?

_____

_____

_____

_____

3. Between the time period of June 1981 and December 1982 have you experienced any of the following? (Please check the appropriate box. If yes, circle a number indicating how stressful that change was).

			If yes, how stressful?						
			Not at all stressful			Somewhat stressful			Very stressful
a.	an increase in the occurrence of health related symptoms.	yes __ no __	1	2	3	4	5	6	7
b.	a change in the client population with whom you are responsible to treat.	yes __ no __	1	2	3	4	5	6	7
c.	a change in the physical location where you are required to provide treatment.	yes __ no __	1	2	3	4	5	6	7
d.	an increase in the amount of direct clinical care.	yes __ no __	1	2	3	4	5	6	7
e.	a decrease in colleague support.	yes __ no __	1	2	3	4	5	6	7
f.	an increase in disagreement with superiors concerning appropriate treatment programs.	yes __ no __	1	2	3	4	5	6	7
g.	a decrease in administrative support.	yes __ no __	1	2	3	4	5	6	7

			If yes, how stressful?						
			Not at all stressful			Somewhat stressful			Very stressful
h.	an increase in record-keeping procedures.	yes ___ no ___	1	2	3	4	5	6	7

4. People respond to stress in many different ways. When you experience job stress, how frequently do you cope with stress in these ways? (Circle the number for each item).

		Never			Sometimes			Frequently
a.	by being absent.	1	2	3	4	5	6	7
b.	by taking vacation time.	1	2	3	4	5	6	7
c.	by going into therapy yourself.	1	2	3	4	5	6	7
d.	by thinking about changing jobs.	1	2	3	4	5	6	7
e.	by talking with another staff member.	1	2	3	4	5	6	7
f.	by taking long lunch hours.	1	2	3	4	5	6	7
g.	by talking with a supervisor.	1	2	3	4	5	6	7
h.	by leaving the unit and taking a break during the day.	1	2	3	4	5	6	7
i.	by volunteering for other kinds of work.	1	2	3	4	5	6	7
j.	by catching up on case records.	1	2	3	4	5	6	7
k.	other (specify)_____	1	2	3	4	5	6	7

5. Place a percentage in the area provided to indicate the amount of time you spend working in each category. (Percentage based on work week).

   Nonchronic ____; Chronic clients ____; Training ____; Supervision ____; Administration ____.

   (Please use this definition of chronic: this population is best described by an ongoing, lingering illness of one year or more of severe impairment. The level of functioning demonstrates major impairment in the areas of work, family relations, psychosocial functioning, judgment, thinking and/or mood disorders.)

6. How many years experience have you had working with:

   a. nonchronic clients: _____ years
   b. chronic clients: _____ years

7. How have your expectations about client improvement changed since you started to work? (Check one statement)

   _____ I expect much less client improvement than I used to.
   _____ I expect somewhat less client improvement than I used to.
   _____ I expect the same client improvement as I used to.
   _____ I expect somewhat more client improvement than I used to.
   _____ I expect much more client improvement than I used to.

8. My professional discipline is _____

   _____.

THANK YOU!

APPENDIX B

STUDY OF MENTAL HEALTH

WORKER STRESS SUMMARY

The purpose of this research is to study on-the-job stress among mental health workers. It is completely voluntary and involves therapists in the Salt Lake County Division of Mental Health. It consists of two parts:

1. A questionnaire focusing on mental health workers' perceptions of job stress; and

2. A comparison of absenteeism data with the questionnaire responses on a group basis.

This research is being undertaken to fulfill partial requirements for my Master's thesis in the University of Utah Psychosocial Nursing Program. Your cooperation will be greatly appreciated.

Individual responses will be held in strict confidence. The information from the questionnaire and absenteeism data will be reported in aggregate form only. At no time will respondents' names or units be shown in conjunction with these data. After compilation and analysis of the data by one of the research staff, all raw data and questionnaires will be destroyed. The amount of time required to answer the questionnaire is approximately twenty minutes to complete. Data will be reported to Management Team, Unit Managers, and line staff.

Please indicate below if you are willing to participate and sign on the signature line.

Thank you,

Cheryl Steadman, B.S., R.N.
(Candidate for M.S. Degree)

I am willing to complete the questionnaire and have my absenteeism data analyzed by a member of the research staff. I understand that at no time will my name be shown in conjunction with the data and that the data will be reported in group form only. (Please place the last four digits of your Social Security Number in the space provided).

_____ _____ _____

(Signature) (SS#) (Date)

APPENDIX C

ANOVA SUMMARIES

Table 17

ANOVA Summary: Effect of Therapist on Number of Changes

Source of Variation	Sum of Squares	df	Mean Square	F
Total	124.244	40	3.106	
Therapist	2.698	1	2.698	(.866)
Error	121.546	39	3.117	

Table 18

ANOVA Summary: Effect of Therapist on Sum of Change

Source of Variation	Sum of Squares	df	Mean Square	F
Total	4262.426	40	106.561	
Therapist	80.509	1	80.509	.751
Error	4181.914	39	107.229	

Table 19

ANOVA Summary: Effect of Perceived Change and Therapist Caseload on Episodes of Absenteeism

Source of Variation	Sum of Squares	df	Mean Square	F
Total	401.051	37	10.839	
Perceived Change (A)	19,866	1	19.866	1.784
Therapist Caseload (B)	1.043	1	1.043	.094
A X B	.294	1	.294	.026
Error	378.555	34	11.134	

Table 20

ANOVA Summary: Effect of Perceived Change and Therapist Caseload on Hours of Absenteeism

Source of Variation	Sum of Squares	df	Mean Square	F
Total	12801.516	36	355.598	
Perceived Change (A)	30.203	1	30.203	.080
Therapist Caseload (B)	43.980	1	43.980	.117
A X B	288.871	1	288.871	.766
Error	12447.824	33	377.207	

Table 21

ANOVA Summary: Effect of Perceived Change and Therapist Caseload on Burnout

Source of Variation	Sum of Squares	df	Mean Square	F
Total	593.802	40	14.845	
Perceived Change (A)	71.353	1	71.353	5.879
Therapist Caseload (B)	1.468	1	1.468	.121
A X B	69.931	1	69.931	5.762
Error	449.037	37	12.136	

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